DOCUMENT RESUME

ED 376 404 CG 025 810

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TITLE The Incest Survivor Syndrome: Implications for Assessment and Treatment.
PUB DATE [94]
NOTE 18p.; Paper presented at the Annual Meeting of the American Psychological Association (101st, Toronto, Ontario, Canada, August 20-24, 1993).
PUB TYPE Speeches/Conference Papers (150) -- Information Analyses (070)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Child Abuse; Cognitive Development; Coping; *Emotional Disturbances; *Incest; Interpersonal Relationship; *Mental Health; Outcomes of Treatment; Parent Child Relationship; Personality Problems; Psychotherapy; *Sexual Abuse; Sexuality; Therapy; *Victims of Crime
IDENTIFIERS *Posttraumatic Stress Disorder; Survivors

ABSTRACT

The past decade has witnessed a growing awareness of the prevalence and consequences of childhood sexual abuse. This paper presents findings from numerous studies which indicate that adult survivors of incest suffer from devastating personal and interpersonal difficulties. Recent studies on incest claim that some 20 percent of females and over 16 percent of males, suffered an incestuous episode at some point in their childhood. Survivors often reveal in therapy a variety of cognitive, emotional, physical, and interpersonal difficulties. These problems and their interactions form the incest survivor syndrome. Because of the powerful consequences of incest on the victim, a diagnosis of post-traumatic stress disorder needs to be given to the survivor in addition to the diagnosis of the presenting complaint. A dual diagnosis will assist the clinician, the patient, and his/her family in normalizing the presenting problems and in depathologizing the survivor. The multiplicity of survivors' problems calls for an integrative treatment approach which is technically eclectic, including among other strategies and techniques, cognitive/behavioral, psychodynamic, and family systems work. Additionally, treatment of married survivors, or those in committed relationships, should include spouses or partners. (Contains 49 references.) (RJM)

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THE INCEST SURVIVOR SYNDROME: IMPLICATIONS FOR ASSESSMENT AND TREATMENT

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In the past decade there has been a growing awareness of the prevalence and consequences of childhood sexual abuse. Societal recognition of the severity of the problem has occurred in an atmosphere of open and frank discussions of sexual attitudes, behaviors, and experiences. Within this climate, there have been increasing reports of childhood sexual experiences and incest in the general population. As a result, there has been growing interest in the area among clinicians who confront the individual, couple, or family problems associated with incest whether they are in private practice or in other clinical settings.

This paper will present findings from a host of research and clinical studies that indicate that adult survivors of incest suffer from devastating personal and interpersonal difficulties. It will also describe four different categories of presenting problems which often bring survivors into treatment. These areas of dysfunction and the interactive effects form what we call the incest survivor syndrome. The paper will close with a discussion of the syndrome and its relationship to the diagnosis of post-traumatic stress disorder.

Epidemiology

According to Russell's landmark study (1986), a substantial percentage of the female population, as high as 1 in 5, has had an incestuous experience at some point in childhood. Most of these victims have been sexually abused before the age of 14. Other studies, most notably one by Porter (1986) have claimed that 1 boy out of 6 will have been sexually victimized by the age of 16, although the incidence for incest has not been established. Russell (1986) has also observed that the majority of perpetrators are male for both male and female victims.

Because incest occurs during childhood, the victim is especially vulnerable to being traumatized for life. An increasing group of investigators has concluded that the victim's later maturation and development will be adversely affected. Browne & Finkelhor (1986) have reported that about 40% of all survivors end up requiring psychotherapy in adulthood.

There is also an emerging awareness among clinicians in both inpatient and outpatient settings that a substantial portion of their caseloads are incest survivors. Studies of outpatients have found that between 25% to 44% of all outpatients are survivors (Briere, 1984; Rosenfeld, 1979; Spencer, 1978; Westermeyer,

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1978). Carmen, Rieker, and Mills (1984) reported that 43% of the adult inpatients in their sample were victims of childhood physical and/or sexual abuse. Similar results were obtained by Emslie and Rosenfeld (1983) in their study of hospitalized children and adolescents. They found that 37.5% of all non-schizophrenic girls, and around 8% of the boys had been incestuously victimized.

As more information has appeared about the prevalence and probable consequences of incest, various theoreticians have called into question some of the sacred cows in psychology. Most notable among these widely-held beliefs are Freud's oedipal and seduction theories in which he claimed that his patients' reports of being sexually abused were merely fantasies arising out of their libidinal drives. In the wake of myriad reports on the reality of incest, these theories have been attacked by feminist writers (Rush, 1980), and psychoanalysts alike (Masson, 1984, and Miller, 1981; 1983; 1984; 1990).

In light of these developments, researchers, clinicians, and theoreticians are studying the relationship between the trauma of incest and the later development of psychopathology. As Miller (1990) points out, it was Freud who first made the connection about a 100 years ago, between adult hysteria and childhood incest but it was also Freud who turned away from his own discoveries. We are apparently returning to the fertile field of inquiry abandoned by Freud in 1897.

THE INCEST SURVIVOR SYNDROME

While the specific relationship between early traumas and the later development of psychopathology in survivors is under investigation (Rieker & Carmen, 1986), it has become increasingly clear to clinicians that a whole host of symptoms are generally related to the complex of experiences surrounding the incest. We need, therefore, to better understand the special needs of this population. In particular, clinicians require a more comprehensive picture of what symptoms their patients bring into treatment and how these presenting problems are related to the incest. Only then can we begin to formulate successful treatment plans.

These symptoms include: low self esteem; anxiety disorders and chronic depression; eating disorders; drug and alcohol abuse; sexual dysfunction; and, abusive marital and/or incestuous family relations. We have tried to classify the most common problems brought by survivors into four areas: cognitive, emotional, physical/somatic, and interpersonal. While other classifications are of course possible, we have attempted to simplify the task by presenting those issues which most often motivate incest victims to seek psychotherapy. Since most survivors do not seek treatment because of childhood incest, clinicians must be aware of the possibility of incest if their clients present with problems in several of the above categories which we will detail shortly.

While survivors do not have to present with serious

psychopathology in all four areas, they often will fall on a continuum of moderate to high dysfunction in all categories. This nexus of problems from the four areas and their interaction effects form the *incest survivor syndrome*.

Cognitive Problems

The most pervasive difficulty with which survivors struggle are issues in self-esteem and self-concept. Poor self-esteem and self-references which are chronically negative are commonly reported. Survivors also believe that they are inherently bad because there is something fundamentally wrong with them. Two separate studies, Herman (1981), and Lundberg-Love (1990), reported that nearly 100% of their female survivors felt stigmatized, damaged, and/or irreparably branded.

Survivors also share a predominant belief that they are unlovable. Whether this faulty belief stems from feelings of guilt or self-blame over the incest is unclear. Nevertheless, as a group, survivors, despite evidence to the contrary, from spouses, lovers, children, and therapists, continue to persist in their belief that they are unlovable and bad.

Survivors may also suffer from learning difficulties and poor attention spans. These disabilities often begin in childhood or early adolescence when the abuse is taking place. As adults, the cognitive problems may manifest as gaps in memories, childhood amnesia, thought disorders, or as enduring concentration and learning difficulties.

Several studies have documented the clinical observation that most survivors suffer from some degree of dissociative disorder. Browne and Finklehor's excellent review of the literature (1986) concluded that dissociation is a long-term consequence of incest. Briere (1984) reported that 41% of his sample experienced dissociation, 33% derealization, and 21% had out-of-body experiences. Lundberg-Love, Crawford, and Geffner's study of survivors (1987), found that 61% of their sample exhibited dissociative symptoms.

Another manifestation of the dissociative disorder is a form of psychological splitting. The survivor develops two distinct aspects of self-representation, a "good me" and a "bad me". In certain cases, the "good me" will overcompensate for the shameful existence of the "bad me" through overachievement and/or perfectionism. In its extreme form, the splitting process may result in multiple personality disorder, that is, the birth of a host of distinct personalities of various ages and different genders. A recent study by Putnam (1989) found that about 85% of patients with the diagnosis of multiple personality disorder had a history of sexual abuse.

Emotional Problems

Survivors often come to therapy with symptoms of anxiety and depression (Briere & Runtz, 1985). Anxiety disorders like agoraphobia are common and will often bring survivors into treatment. Chronic depressive reactions may also occur in

adolescence and persist well into adulthood. In our view these are long-term post-traumatic reactions to the incest.

Let us look at some common anxiety or fear reactions. Nightmares, night terrors, insomnia, and fears of sleeping alone are typical symptoms. Nightmares and night terrors are usually recurrent in nature with basic themes of being chased, hunted, captured or suffocated. Survivors who are also parents may have fears of being alone at night as well as manifest extreme vigilance over the children when they are sleeping.

Some survivors present with fears of losing their loved ones, especially their partners or spouses. Profound separation anxieties or abandonment terrors are expressed by some patients as early as in the first few sessions. Others will report that they are afraid of being killed or annihilated even in situations where there is no imminent danger. These fears are often expressed as having arisen in night terrors or nightmares. Those clients who are torn between fears of abandonment and annihilation will often present as lethargic, depressed, and almost paralyzed individuals.

According to a study by Briere & Runtz (1986) survivors are much more likely to consider or attempt suicide. They are also much more prone to self-mutilating behaviors using cigarettes or razor-blades. These activities reflect the underlying depression and lack of a desire to live which are characteristic of this population. Several studies with college-age girls have confirmed higher rates of depression among both clinical and nonclinical samples (Sedney & Brooks, 1984; Lundberg-Love, Crawford, and Geffner, 1987).

Some survivors present with deadened affect and a quality of numbness. They can report on unspeakable horrors that have occurred to them without betraying any emotion. These clients have adhered to the family rule of "Don't talk, don't trust, don't feel" (Black, 1981).

Still another category of emotional reaction to the incest is a persistent and pervasive feeling of shame. Survivors will often report feelings of wanting to hide from the world, or that they do not deserve to live. Other survivors suffer from chronic guilt over almost anything--especially enjoyment. Their children's successes, spending money, or pleasure over eating, are sources of or triggers to experiences of guilt. These feelings come out early in treatment and are not repressed or even suppressed as they are with many other types of clients. Survivors often display what Seligman (1975) has called "learned helplessness." In the face of chronic abuse and denigration, the victims come to experience themselves as impotent and helpless. They have learned to not assert their desires or will, nor to express their feelings or beliefs. The apparent passivity and high degree of apathy which these clients display is similar in some ways to that witnessed in concentration camp survivors.

Physical/Somatic

Survivors will also complain of many physical disorders. Common symptoms are gastro-intestinal disorders, chronic tension,

migraines, insomnia, chronic itching or pain in the vaginal area, and nausea. Unlike some writers who see these as psychosomatic complaints or as conversion symptoms, (e.g. Courtois, 1988), we prefer to view the disorders as physical reactions to extreme stress in the same way we view ulcers.

Abused children live and face tremendous fear and stress daily. Since they are unable to flee the situation and are captives of their families, their bodies produce tremendous amounts of adrenaline and norepinephrine. No wonder then that they suffer from chronic gastro-intestinal and other stress-related disorders.

Lundberg-Love, Crawford, and Geffner in their 1987 study of female survivors found a high incidence of somatic complaints. About 50% of their sample reported gastro-intestinal problems, pains, and headaches, while 53% were found to have eating disorders. Sedney and Brooks' college sample (1984) reported chronic tension (41%), insomnia (51%), and anxiety and nervousness (59%). The latter study's findings are extremely interesting for two reasons. The sample was a non-clinical population which makes the results even more powerful. In addition, the findings suggest that the post-traumatic effects of incest are already in place by late adolescence and young adulthood.

Many female survivors report chronic discomfort, pain, and infection in the vaginal or rectal areas. These complaints coupled with the feelings of shame that clients have carried with them make it extremely difficult for them to undergo routine gynecological exams. Many of our clients are automatically referred to female gynecologists because the survivors had refused to be examined by a man and then through inertia had not gone to see anyone for years. One client would faint everytime she was examined and would awaken only after the exam was complete.

Another common complaint is chronic nausea. Often the nausea is reported in anticipation of or during sex. This condition is especially prevalent when the survivor has a history of incest which included oral sex. Both males and females will often find it impossible to enjoy either giving or receiving oral sex as a result of the extreme nausea which they experience. We view the nausea as a learned response to the incest. Indeed, like the symptom of helplessness, survivors learn certain kinds of responses at the time of the abuse which were adaptive to the intolerable situation. Over time, these responses take on a life of their own even though they may no longer be appropriate.

Eating disorders and Substance abuse

Two other types of serious physical problems will often bring survivors into treatment: eating disorders, and drug or alcohol abuse. A number of recent studies have shown that a very high percentage of anorexics and bulimics are survivors of childhood sexual abuse. Lundberg-Love et. al. (1987) found that 53% of their sample suffered from eating disorders. Cornelius (1991) reported that 61% of the women treated at the Renfrew

Center, a center for treating eating disorders, had been sexually abused as children.

Many clinicians including Courtois (1988) have confirmed our clinical experience that incest often occurs in the context of an alcoholic family. For example, Virkkunen (1974) and Meiselman (1978) found that up to 50% of incest fathers could be considered alcoholic. As children of alcoholics, survivors are at great risk to become chemically dependent themselves. Indeed, recent studies have confirmed our clinical findings that as many as four out of ten survivors are abusing or have abused drugs and/or alcohol. Lundberg-Love, Crawford, & Geffner (1987) found that 42% of their sample were substance abusers and this group tended to abuse more than one type of substance. Similarly, Briere (1984) found that 27% of his female survivors had a history of alcoholism and 21%, a history of drug abuse as compared with 11% and 2% of non-survivors, respectively. Herman's study (1981) of incest victims reported that 35% abused drugs and alcohol.

We have also seen a substantial minority of family cases in which the husbands are survivors of sexual abuse and are themselves both perpetrators and alcoholics. In some of these cases, the spouse may also be a survivor who is not an abuser herself but functions as a codependent partner. In many instances, this entire pattern of the weak and co-dependent woman, and the alcoholic man who abuses their daughter may represent the intergenerational transmission of alcoholism, codependency, and sexual abuse. Indeed, two different reports of male perpetrators (Kaufman and Zigler, 1987; Pelto, 1981), have shown that between 30% to 50% of them were either sexually abused or witnessed incest between their fathers and sisters.

Interpersonal Problems

Survivors often come to therapy with interpersonal issues as their primary concern. Difficulties in committing to or maintaining satisfying intimate relationships, parenting problems, revictimization, and a host of sexual issues are at the top of the list. Numerous studies have shown that female survivors in comparison with controls, are severely conflict-laden, experience rage and ongoing hostility to both their parents, and hold all women in contempt. Courtois' data (1979) indicated that 79% of her female sample reported moderate to severe problems relating to men. Against this backdrop it is understandable that a substantial percentage of these women are unable to commit to an intimate relationship. Three studies have corroborated that female survivors were less likely to get married than non-survivors (Meiselman, 1978; Courtois, 1979; Russell, 1986). The data in these studies ranged from a high of 40% to a low of 30% of the women never having been married.

The most pervasive problems faced by survivors in relationships are around issues of intimacy. Lundberg-Love's data (1987) showed that 89% reported an inability to trust people, while 86% had difficulties dealing with close relationships. Meiselman's study (1978) comparing female survivors with a group of controls showed that 64% of survivors reported conflict and

fear with spouses and lovers as compared with 40% of the controls. Because of their lack of trust and the accompanying feelings of fear and anger, survivors have severe difficulties in allowing significant others, especially partners or spouses, to nurture or give to them. They will either rigidly maintain the caretaking role in the relationship or distance themselves. Often, they will complain, especially in couples work, that their partner does not attend to them, but, when the therapist intervenes to rectify the situation, the survivor tends to not cooperate. The survivor's inability to be in the cared for role stems from both a fear of being dependent and the terror of being hurt again.

Another factor which contributes to the dynamics of rigid roles in the couple is the survivor's basic belief that she is unlovable and not worthy of caretaking. While that belief system persists, transactional work with the couple will not be successful.

Survivors who are able to get married and have children often experience severe anxieties in relation to their children. They will play out their fears of being abused by being hypervigilant over their children's safety, both in going to or coming home from school, fears about strangers hurting them, and as mentioned earlier, about their safety after being put to sleep. Survivors often become highly anxious about their spouses or partners becoming perpetrators either because they have chosen a potential or actual perpetrator or because they have generalized their fears to include all men.

Some survivors do present with children in treatment who have either been physically or sexually abused. These children, in turn, are often referred because of school truancy, serious acting-out in school, or by the police.

Another serious consequence of incest is sexual revictimization. The Lundberg-Love et. al. study (1987) found that 50% of their sample had been sexually revictimized. Other studies have also concluded that survivors are at serious risk to be raped or to be victimized in non-consenting sexual experiences. For example, in Russell's study (1986), 68% of the survivors had been victims of either rape or attempted rape. Revictimization will often bring survivors into treatment as they seek to understand why they are always being hurt.

In the past decade, a number of clinically-based studies have corroborated what clinicians have seen in their consulting rooms: the devastating consequences of incest on later adult sexual functioning (Meiselman, 1978; Herman, 1981; Briere, 1984; Lundberg-Love, 1990). These studies have shown that as many as 87% of women studied reported sexual problems. Studies using non-clinical samples have also shown that survivors as young as college age score significantly lower on a measure of sexual self-esteem than controls (Finklehor, 1979). And Courtois (1979) showed that up to 80% of non-patient survivors reported sexual difficulties.

We have found it useful, following Sprei and Courtois (1988), to classify six different types of sexual dysfunction which are often given as reasons for entering either individual

or couples therapy. These are: desire di
disorders, orgasmic disorders, coital pai
satisfaction difficulties, and qualifying
Friedman, Weiler, Heiman, & LoPiccolo, 19

Desire disorders fall into two categ
and an aversion to or disgust with sex. I
al. study (1987), 67% of female survivors
to sex. Briere (1984) reported that 42%
experienced low sexual desire. These studies suggest that incest
victims have been negatively conditioned to sexual activity. As
with other learned responses, these behaviors can be difficult to
extinguish if they are not understood in the context of the
incest. Maltz and Holman (1987) have observed that since the
sexual abuse probably constituted the child's first experience
with sex, negative conditioning in survivors is very strong.

Arousal disorders are common to both male and female
survivors. In men, victims have problems with impotence and/or
maintaining erections either during foreplay, oral sex, or
intercourse. These difficulties are present among both
homosexuals and heterosexuals. The sexual preference of the
client does not appear to lessen the traumatic consequences of
the incest where sexual arousal is the issue.

In female survivors, arousal problems manifest themselves as
lubrication difficulties or no lubrication at all. If intercourse
is then attempted, pain is sure to follow. Many couples (or
individuals) who present in sex therapy with this problem are
usually unaware of the symptom's connection with an incest
history. Other women may suffer from a lack of sensation or a
type of numbness in the vaginal area which precludes the
possibility of arousal. The Lundberg-Love et. al. sample (1987)
reported that 36% had problems in becoming sexually aroused.

Orgasmic disorders are also common to both male and female
survivors. Problems with retarded ejaculation or a total
inability to achieve orgasm occur frequently among men. Among gay
men, these difficulties may be presented as the result of not
"being around the right kind of lover" and other similar
explanations. In women, survivors may be able to achieve orgasm
only through solitary masturbation. We have found that even
manual stimulation by a spouse will often fail to bring the woman
to orgasm. In many women solitary masturbation may be
experienced as the only safe way to enjoy sexual activity
(Courtois, 1988).

Survivors are often referred by their physicians or
gynecologists because of severe coital pain, vaginismus, or
dyspareunia. Vaginismus results from involuntary muscle spasms
during intercourse. Dyspareunia, defined as pain experienced
during intercourse, comes from the Greek word for "unhappily
mated as bedfellows." These symptoms can prevent the couple from
having sex even though the survivor may very much want to do so.

The Lundberg-Love et. al. study (1987) found that 56% of
their sample reported unsatisfactory sexual relationships. But as
Courtois (1988) has noted many widely divergent patterns exist in
terms of both frequency and satisfaction. In our experience a
substantial percentage of both male and female survivors engage

in sexual promiscuity or acting-out at some point in their lives. In the Lundberg-Love et. al. sample, 58% of the women had engaged in this behavior. While other studies have reported significantly lower figures, their period of observation was considerably less than the two plus year period in the Lundberg-Love, Crawford, and Geffner study (Lundberg-Love, 1990). In our experience, survivors will often oscillate between abstinence and promiscuity depending on life cycle variables like length of relationship, age of children, empty nest, and the survivor's age. Lundberg-Love et. al.(1987) have also observed that survivors may exhibit low sexual drive at one stage of the life cycle while at others they might report more heightened activity.

Qualifying information is what Courtois (1988) refers to in describing other variables which affect sexual functioning. These include: flashbacks, memories, and other intrusions which are triggered by sex. Dissociation and derealization also can occur during sex, which are adaptive in the sense that the survivor is at least able to be physically present. Unfortunately, these states may preclude any sexual enjoyment. Other qualifying information we have found to be important is evidence of physical damage suffered by the victim during the incest.

Another sexual problem which has been recently documented is that of sex addiction. Carnes (1991) has reported that 81% of his sample of male and female sex addicts were sexually abused as children. Of these, 33% of the men and 42% of the women had been abused by their mothers or fathers. The pattern of incest leading to sex addiction and possibly to further incest has only been recently identified and requires further study.

IMPLICATIONS FOR ASSESSMENT AND TREATMENT

Assessment Issues

The concept of incest survivor syndrome has been developed as a useful guide to clinicians who work with victims of incest. In our experience, survivors who come for treatment suffer dysfunction in every major aspect of their lives. Even those patients who, for example, may have successful careers are apt to be unable to enjoy that success and/or live in tremendous fear of abandonment or annihilation. This group of survivors, in particular, will often ask how it is possible that events which occurred so many years in their pasts could so profoundly influence them today. How, then, can we understand the onset and intractability of the syndrome and its apparent relationship to the incest trauma?

As we discussed earlier, survivors have been subject to extreme conditions of stress. As children, they grew up in families in which they could not exert control over their parents' behavior, especially the perpetrators', or ultimately over their own boundaries and space. Some survivors lived in unpredictable conditions, not knowing when they would be violated

next, or if they or others would be beaten. Calof (1987) has described these unpredictable conditions as reflecting intermittent reinforcement conditions in which the child is loved one day and abused the next, under similar contingencies. The consequence of this systemic context is that many survivors lived in fear and developed the condition of "learned helplessness."

Indeed, the Seligman experiments shed light on the stressful conditions under which abused children live, and their subsequent reactions to those stressors. Seligman (1975) created an experimental situation in which dogs were trained to avoid being shocked by learning to jump from one compartment to the next. Then Seligman raised an impenetrable barrier which made it impossible for the dogs to jump and hence avoid the electric shock. Over time he observed that the dogs exhibited increased passivity, decreased performance, isolation, and an apparent loss of motivation. Garber and Seligman (1980) observed that even when the painful shock was absent, neither the passage of time, nor reexposure to the same situation, seemed to ameliorate the helplessness or the depression.

When we compare Seligman's experimental conditions with those endured by many abused children, we can see the similarities: the subjects are trapped, have no control over the situation and are powerless to stop their oppressors. Seligman's observations of the lab animals' behavior also have several important commonalities with the reports of adult incest survivors: persistent and enduring feelings of intense fear, helplessness and dysphoria.

Because incest is stressful and typically inescapable for most children, it is quite understandable that survivors would develop lasting reactions to being molested by family members. Children's coping mechanisms leave them ill-equipped to deal with a trauma which is outside the range of their expectations of normal family relations. In that sense, incest is a traumatic event as defined by DSM III-R (1987) in that it is a distressing experience which would upset almost anyone, which occurs outside the range of usual human experience.

Furthermore, survivors' reactions to the trauma also meet the criteria set forth in DSM III-R for Post-Traumatic Stress Disorder (PTSD). As we detailed earlier, research has shown that survivors suffer from flashbacks and recollections of the trauma, and may have: numbing of affect; feelings of isolation or detachment; dissociative disorders or psychogenic amnesia; hypervigilance; difficulties falling asleep; and, symptoms of anxiety and depression. All of the above symptoms are part of the criteria for PTSD in DSM III-R. In sum then, there can be little doubt that the extremely stressful situations surrounding the incest (including the familial control, denial and enforced silence) create intolerable psychological conditions for the victim. Over time, these conditions give rise to the reactions which typify the incest survivor syndrome.

We concur with Briere (1984) who has called for a diagnosis of post-sexual abuse syndrome. Courtois (1988) has argued convincingly that PTSD should be used as the principal Axis I diagnosis or as a secondary diagnosis to survivors' other

symptoms. The reader is referred to her excellent review of the current literature on PTSD and the incest trauma.

Along with Courtois, Briere, and others, we believe that the evidence is compelling to consider the PTSD diagnosis alongside the diagnosis for one or more of the client's other symptoms. It is time for practitioners to have in mind a dual diagnosis when treating clients who are incest survivors and who present with various symptomatology. Keeping a dual diagnosis in mind will remind both the clinician and the client (or client family) that the presenting difficulties are responses to and legacies of an intolerable situation. And, normalizing the client's symptoms and de-pathologizing the survivor are integral parts of a successful treatment plan. The dual diagnosis view, then, helps to facilitate the normalizing process for all treatment participants including the therapist.

Treatment Issues

No single approach, be it cognitive/behavioral, psychodynamic or family systems, can, by itself, deal with the multiproblem presentations of survivors. Rather, the breadth of their individual and interpersonal problems calls for a comprehensive and integrative treatment plan. The plan would be considered to be technically eclectic and would include techniques from various therapeutic perspectives, organized around the goal of maximizing change (Beutler, 1989; Lazarus & Messer, 1991).

In this treatment schema, each of the four major problem areas presented by survivors would be addressed. For example, survivors' fears, phobias and other cognitive distortions would require cognitive/behavioral work. The clinician might use psychodynamic, gestalt, and other emotive work in order to facilitate the memory retrieval process. The practitioner might need to treat the anxiety and depressive disorders with a brief course of anti-depressants, along with psychodynamic techniques and anger-releasing gestalt role-play. The survivors' physical/somatic complaints might call for relaxation training, biofeedback, and any necessary drug and alcohol treatment. Finally, the survivors' interpersonal problems would require couples and family therapy targeted to help: their sexual and intimate relationships with spouses/partners; their parenting of children; and, their relationships with members of the family of origin.

Additionally, since the survivor syndrome shows consistent patterns of anxiety and depression, for the survivor who is in a committed relationship, inclusion of the spouse/partner in the whole treatment process may be beneficial. There is considerable support in treatment outcome research for including the spouse in treatment for anxiety and depression. For example, Barlow, in a series of studies (1983, 1984), found that including spouses in treating agoraphobics was more effective than individual therapy in terms of symptom relief and positive effect on measures of the patients' social, work, and family functioning.

Conversely, not including spouses in treating survivors, may

either hurt the relationship, or negatively affect the partner. Hafner (1977), Milton & Hafner (1979) and others have found that successful individual therapy of married female agoraphobics is associated with deteriorating marital relations and/or the emergence of psychiatric symptoms in the husband. Coyne (1987) also found similar results with married depressives who were treated individually.

Coyne (1987) has also found that depressed women with marital problems were less likely to improve in individual therapy than those patients who had fewer marital difficulties. And, patients from unsatisfactory marriages were also significantly more likely to relapse upon follow-up. Bland & Hallam (1981) found a significant difference between "good marriages" and "poor marriages" with respect to relapse rates. Given that survivors often suffer from anxiety disorders like agoraphobia and depression (e.g. Sedney & Brooks, 1984; Lundberg-Love, Crawford, & Geffner, 1987; Lundberg-Love, 1990), including their partners in treatment makes good sense.

Following these treatment implications, we have developed an integrated approach for treating incest survivors, which combines cognitive-behavioral, psychodynamic, and systemic treatment modalities. For married clients or those in committed relationships, the therapy process goes through seven stages. These are: 1) individual sessions with the survivor in which traumatic memories are recovered and emotions ventilated; 2) joint sessions with the survivor's spouse or partner in which symptoms are reframed and normalized; 3) individual and conjoint meetings in which cognitive restructuring, in vivo exposure, desensitization, relaxation training, and other cognitive-behavioral techniques are used to help alleviate presenting symptomatology; 4) preparing the survivor and partner for sessions with the family of origin through behavioral rehearsal, role playing, and assertiveness training; 5) family therapy sessions in which the survivor meets with the surviving parents and siblings and discusses the details of the abuse and its effects; 6) follow-up family sessions and contacts via letter to effect reparation, forgiveness, and resolution; and, 7) marital therapy sessions in which sex-therapy techniques and communications skill-building training are emphasized.

In this approach, partners are brought in from the outset of treatment as therapeutic allies to help the survivor deal more effectively with the incest trauma. The goal of this strategy is to create a corrective transactional experience for the survivor in which two important people, spouse and therapist, are in a constructive alliance with the survivor. The reader is referred to the text, Working with adult incest survivors: The healing journey, (Kirschner, Kirschner, and Rappaport, 1993) for a more complete description of an integrated treatment approach for incest survivors.

SUMMARY

Survivors often present in therapy with a variety of cognitive, emotional, physical, and interpersonal difficulties.

These problems and their interaction effects form the incest survivor syndrome. Because incest has powerful consequences on the victim, a diagnosis of post-traumatic stress disorder needs to be given to the survivor in addition to the diagnosis of the presenting complaint. A dual diagnosis will assist the clinician, the patient, and his/her family in normalizing the presenting problems and in depathologizing the survivor.

The multiplicity of survivors' problems calls for an integrative treatment approach which is technically eclectic, including, among other strategies and techniques, cognitive/behavioral, psychodynamic, and family systems work. Additionally, treatment of married survivors, or those in committed relationships, should include their spouses/partners.

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